Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969246	A. BUILDING: _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATED ESTATES EDWINOLA LLC	14235 EDWINOLA WAY DADE CITY, FL 33525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint (complaint numbers 2025006276;2025006445) survey was conducted at Elevated Estates Edwinola on . Deficiencies were identified at the time of survey. amended	A 000		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the	A 056		

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A 056	Continued From page 1 medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the	A 056		

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A 056	Continued From page 2 resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner for one resident (# 10) of two sampled residents. This failure placed the resident at significant risk for life-threatening health complications. Findings included: A record review, on at 3:47 PM, revealed Resident #10 was not given the prescribed life-altering medication. A review of the Resident #10's Medication Observation Record (MOR) showed that the medication was discontinued by the facility provider on due to Resident #10 not being able to	A 056		

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A 056	Continued From page 3 see an physician for a new prescription. During an interview on at 4:55 PM, the Resident #10's (IDS) stated that Resident #10 being off the medication led to uncontrolled activity, which was life-threatening. The IDS stated that if the situation had not been addressed, it could have resulted in severe , or even of the resident. The IDS emphasized that no significant health changes should have occurred within the two-week period Resident #10 did not received his medication. The IDS stated that if Resident #10 resumes the medication as soon as possible, Resident #10 should recover without significant issues. During an interview on at 2:40 PM, the facility's Corporate Wellness Associate stated that the pharmacy required a new prescription from Resident 10's Physician and the family did not want to pay for the medication. As a result, the facility provider discontinued the medication on . During an interview on at 1:21 PM Resident#10 confirmed not receiving the medication and that it could lead to if the medication was not taken as prescribed. During an interview on at 5:45 PM, the Administrator acknowledged that the facility did not take all appropriate measures to ensure Resident #10 received his medication as required. The Administrator expressed a clear understanding of the serious implications of the facility's actions and the potential consequences that could have arisen as a result.	A 056		

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A 056	Continued From page 4 During an interview on at 3:31 PM, Resident #10's , stated Resident #10's family representative called the office on and informed them that Resident #10 was not receiving the medication. The Office contacted the facility on and informed them that Resident #10 needed to have laboratory completed and be restarted on the medication. The Office stated the office nurse left a voicemail for the Director of Nursing however no one from the facility called . A record review of office notes from Resident #10's , on at 4:06 PM, revealed that Resident #10, had a history of an advanced medical condition and had not received the prescribed medication for this advanced medical condition while residing at the facility. The record revealed on Resident #10's family representative and healthcare proxy contacted the office to report Resident #10's worsening condition. The record showed the office contacted the facility on and advised that Resident #10 needed to be restarted on the prescribed medication for this advanced medical condition immediately and to have laboratory testing completed. The record noted a voicemail was left for the facility's Director of Nursing; however, no return call was received by the office. Class II	A 056		